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ORIGINAL ARTICLE

## Encounters between workers sick-listed with common mental disorders and return-to-work stakeholders. Does workers' gender matter?

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### Abstract

**Introduction:** The aims of this paper were to examine how disabled workers assess encounters with return-to-work (RTW) stakeholders during sickness absence due to common mental disorders (CMD) and to investigate gender differences in these assessments. **Method:** Data on contact with and assessment of encounters with RTW-stakeholders were obtained from a questionnaire investigation ( $N = 226$ ). The participants were recruited from employees applying for sickness benefits due to CMD from the Municipality of Copenhagen. **Results:** High support was most often reported from the personal and health system, especially from the psychologists (83%), while encounters with social insurance officers were least often reported to be highly supportive (16%). Colleagues were more often reported to be highly supportive (49%) than supervisors (30%). Gender differences were found both in contact with and assessments of encounters. Women were less likely to participate in a sickness absence interview with the employer, to receive care from a psychiatrist, and also assessed the encounter with the supervisor as less supportive and respectful. Gender differences remained statistically significant after controlling for several covariates, including depressive symptoms. **Conclusion:** The study findings strongly indicate that further attention needs to be directed towards improving the workers' relationship with supervisors and social insurance officers. Findings apply in particular to women.

**Key Words:** Common mental disorders, encounters, return-to-work, questionnaire, stakeholders

### Background

Sickness absence can have serious personal and economic consequences for the disabled worker, and also puts considerably financial strain on employers and social insurance systems. During the last decade, ensuring an early and safe return to work (RTW) has been high on the political agenda in many European countries [1]. However, RTW after long-term sickness absence is a complex phenomenon, which often involves a wide range of stakeholders, such as employers, social insurance officers, and healthcare professionals [2–4]. Several authors argue that friction between the disabled worker and other

RTW-stakeholders is inevitable due to conflicting interests and perspectives on work reintegration [2,4–8]. Whereas empirical evidence is still limited [7,9,10], current theories propose that positive relationships can improve the workers' chance to RTW [2,3]. So far, qualitative studies have highlighted the importance of an atmosphere of goodwill and trust at the workplace [7], and respectful and supportive treatment (e.g. to be listened to and taken seriously) by healthcare professionals and social insurance officers [11]. Although these findings have contributed to our understanding of aspects important for

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positive relationships from the workers' point of view, several questions remain unresolved.

First, to our knowledge no study has yet compared assessments of stakeholders from all relevant systems, including the health, insurance, work and personal systems. Second, common mental disorders (CMD, e.g. depression, anxiety, burnout) are among the main diagnoses for sickness absence and disability pensioning in several countries [12–14], but the majority of RTW-research has focused mainly on musculoskeletal problems [15]. However, workers with CMD might experience encounters with healthcare professionals and social insurance officers differently than workers suffering from other health problems [16]. Earlier, Coyne demonstrated that people who are depressed give social cues that trigger negative reactions from others resulting in negative interactions and a tendency of others to avoid people with depression [17]. Workers with CMD might therefore be more susceptible to experience less supportive and respectful encounters [16].

Third, sickness absence, especially in relation to CMD, is far more prevalent among women [18]. Although gender differences in sickness absence are prominent, few studies have examined such differences in encounters with RTW-stakeholders [16,19]. Bansal and colleagues have argued that emotional distress may impact women's experiences of support from the work place more negatively than men, because women usually receive more support in their personal life [20] and tend to define relationships in emotional rather than instrumental terms [21]. When experiencing emotional distress, women might translate their expectations for support received from their personal lives to the workplace and be more disappointed if support is unavailable [21]. In relation to the clinical setting, studies have shown that healthcare professionals differ in their communication with patients according to the patients' gender [22]. Werner and Malterud [23] have emphasized the importance of awareness of gendered-power structures of imbalance, because medical theory and practice has historically been dominated by men [23].

## Aims

To increase our understanding about the workers' encounters with RTW-stakeholders, the aims of this paper are to: 1) estimate employees' contact with and assessment of encounters with RTW-stakeholders from the health, insurance, work, and personal system; and 2) investigate possible gender differences in these assessments.

## Methods

This study is part of a research project on 'Common mental disorders, Return-to-work, and long-term Sickness Absence' (CORSA), which is a mixed-method study encompassing questionnaire, register and interview data from a cohort of employees sick listed due to CMD [24]. In this paper, we present findings from the follow-up questionnaires developed to investigate the participants' RTW-experiences.

### Procedures

The participants were recruited from the Job Centre of Copenhagen, which is responsible for managing sickness benefits in the municipality of Copenhagen. The study participants were selected among employees resident in Copenhagen, who were sick listed with CMD, and had applied for sickness benefit compensation to the municipality. Social insurance officers from the Job Centre identified eligible employees from July 2007 to December 2007 based on information obtained from sickness benefit application forms filled in by the sick-listed employee ( $n = 721$ ). These applications forms are a mandatory requirement for receiving sickness benefits and are used by the social insurance officers to assess and evaluate the sick listed employee. A baseline questionnaire was sent to all 721 potential participants and was returned by 298 (41% response rate) participants. Six months later, we distributed a follow-up questionnaire to the baseline responders, which was returned by 226 participants (76% response rate, 31% of the original 721 potential participants). A more detailed description of the study design has been reported elsewhere [24].

### Non-response analysis

We have previously reported the sociodemographic, occupational and health characteristics of the whole study sample, and of the responders and non-responders to the baseline questionnaire [24]. For the purpose of the present article, we carried out a non-response analysis comparing the 226 responders to the follow-up questionnaire with all 721 potential participants. Data on age, gender, reason for sickness absence and duration of absence were obtained from administrative forms collected at the Job Centre Copenhagen and the National Registry of Social Transfer Payments. Differences among responders and non-responders were examined with chi-square test. We found that responders were more likely to be women (81% vs. 64%,  $p > 0.01$ ), to be sick-listed with stress/burnout as opposed to more specific

psychiatric diagnoses such as depression and anxiety (55% vs. 45%,  $p = 0.031$ ), and less likely to be manual workers (5% vs. 13%,  $p < 0.001$ ). No differences were found regarding prior sickness absence with CMD, age, and mean and median duration of sickness absence (data not shown).

#### *Characteristics of participants*

Data on age, gender, education, and the characteristics of the workplace (size and public vs. private) were obtained from the baseline questionnaires. Age was dichotomized into 19 to 49 years and 50 years and older. Education was dichotomized into long/medium (3 years or more of upper secondary schooling) versus low (less than 3 years). Size of workplace was categorized into small and medium-sized (less than 99 employees) and large (more than 100 employees) and type of workplace was categorized as public, private and other with the latter category encompassing workplaces that are partially private/public. Current RTW status (returned to work/ not returned to work) and employment situation (same employer/no longer employed with pre-sickness absence employer) was assessed from the follow-up questionnaire. Depressive symptoms at follow-up were measured with the Major Depression Inventory (MDI), which is a clinically validated psychometric scale [25]. The MDI yields a depressive symptom score

with a minimum of 0 and a maximum of 50 points, with higher scores indicating more depressive symptoms.

Table I shows the characteristics of the participants of the whole sample and stratified by gender. The only difference by gender was in size of workplace. Women were more likely than men to work at small and medium-sized workplaces.

#### *Contact with stakeholders and assessments of encounters*

The follow-up questionnaire was constructed to illicit experiences during sickness absence and comprised questions about contact with stakeholders and statements regarding experiences of encounters with stakeholders from all relevant systems; health (general practitioner (GP), psychologist and psychiatrist), social insurance (social insurance officers), work (supervisor, colleagues, unions) and personal (partner, family, friends). These systems have previously been suggested as the main systems involved in the RTW-process [2,3].

We asked the respondents whether they contacted their general practitioner in relation to their sickness absence, if they had been in contact with a psychologist or a psychiatrist during the past 3 months and if they had participated in a personal interview with a social insurance officer and in a sickness absence interview with their employer.

Table I. Characteristics of participants.

	Total ( <i>n</i> = 226)	Women ( <i>n</i> = 182)	Men ( <i>n</i> = 44)	<i>p</i> -value
<b>Age</b>				
–49	109 (48.2)	90 (49.5)	19 (43.2)	0.455
50–	117 (51.8)	92 (50.5)	25 (56.8)	
<b>Educational level</b>				
High	130 (57.5)	102 (56.0)	28 (63.6)	0.361
Low	96 (42.5)	80 (44.0)	16 (34.4)	
<b>Workplace</b>				
Private	96 (43.8)	72 (43.6)	24 (55.8)	0.084
Public	112 (51.1)	93 (56.4)	19 (44.2)	
Other	11 (5.0)	11 (6.3)	0 (0)	
<b>Size of workplace</b>				
1–99	158 (71.2)	133 (74.3)	25 (58.1)	0.036
100–	64 (28.8)	46 (25.7)	18 (41.9)	
<b>RTW status</b>				
Yes	161 (72.5)	126 (70.8)	35 (79.5)	0.244
No	61 (27.5)	52 (29.2)	9 (20.5)	
<b>Employment status</b>				
Same	100 (44.8)	79 (44.1)	21 (47.7)	0.668
Not same	123 (55.2)	100 (55.9)	23 (52.3)	
<b>Major Depression Inventory symptom score (mean, SD)</b>	13.89 (10.99)	14.26 (11.08)	12.33 (10.62)	0.301

Table II. Percentages of contact with RTW-stakeholders and odds ratios (OR) with 95 % confidence intervals (CI) for contact for women compared to men ( $N = 226$ ).

	Total $N$ (%)	Women $N$ (%)	Men $N$ (%)	Crude OR and 95 % CI (men = reference)	Adjusted <sup>1</sup> OR and 95 % CI (men = reference)
<b>Consulted GP<sup>1</sup></b>					
Yes	213 (95.1)	171 (95.0)	42 (95.5)	0.91 (0.19–4.34)	1.83 (0.32–10.38)
<b>Consulted psychologist</b>					
Yes	108 (47.8)	88 (48.4)	20 (45.5)	1.12 (0.58–2.18)	1.18 (0.57–2.43)
<b>Consulted psychiatrist</b>					
Yes	49 (21.7)	32 (17.6)	17 (38.6)	0.34 (0.17–0.69)	0.23 (0.10–0.52)
<b>Participated in personal interview with social insurance officer</b>					
Yes	97 (44.1)	78 (43.8)	19 (45.2)	0.94 (0.48–1.86)	0.88 (0.41–1.91)
<b>Participated in sickness absence interview with the employer</b>					
Yes	112 (50.7)	84 (36.7)	28 (68.3)	0.41 (0.20–0.84)	0.34 (0.15–0.76)

<sup>1</sup>Adjusted for age, education, RTW status and employment and size and type of workplace  
GP = General Practitioner

Next, we asked the respondents to what degree they had received support during their sickness absence from the different stakeholders. Response categories were 1) to a very high degree, 2) to a high degree, 3) partially, 4) to a low degree, 5) to a very low degree/not at all and 6) not relevant. For the analysis we dichotomized the responses into high support (1–2) and low/none support (3–5) and omitted participants who answered ‘not relevant’. Finally, we asked the participants about specific aspects of encounters with social insurance officers and supervisors. We chose to address these two stakeholders in particular because 1) the social insurance officers officially have a key role for RTW in Denmark [1], and 2) policy makers in recent years have implemented policies to strengthen the role of the workplace and the supervisor [1]. Regarding social insurance officers we asked the participants: ‘To what degree did the social insurance officer 1) help you to return to work, 2) display sympathy for your situation and 3) take your condition serious.’ Response categories were ‘yes’, ‘no’ and ‘partially’, and were dichotomized into ‘low support’ (‘no’, ‘partly’) and ‘high support’ (‘yes’). Regarding supervisors, we asked: ‘To what degree did your supervisor; 1) help you to return to work, 2) listen to you, 3) display sympathy for your situation and 4) make you feel you had to justify your absence (reverse-coded).’ Response categories were 1) to a very high degree, 2) to a high degree, 3) partially, 4) to a low degree, 5) to a very low degree/not at all, and were dichotomized into high support (1–2) and low/none support (3–5). The questions on the different aspects on encounters were based on previous findings from qualitative studies [11,19], earlier surveys [16,19,26,27], and theoretical considerations [28].

### Data analyses

Logistic regression analyses were carried out to identify possible associations between gender and assessment of encounters. We calculated odds ratios (OR) and 95% confidence intervals (CI) with men as the reference group. Analyses are presented as both crude OR and OR adjusted for age, education, employment and RTW status, type of work (public/private/other), size of workplace and depressive symptoms. Because depressive symptoms might not only be a confounder for the association between gender and assessment of encounters, but also an intermediate variable, inclusion of depressive symptoms in the model might be over-adjustment. Therefore, we repeated all analyses without adjustment for depressive symptoms.

### Results

The vast majority of the respondents (95%) visited their GP when reporting off sick, whereas 22% received care from a psychiatrist, and 48% received care from a psychologist within the last three months (Table II). Forty-four percent participated in a personal interview with a social insurance officer and 51% participated in a sickness absence interview with their employer. Compared to men, women were less likely to receive care from a psychiatrist ( $p < 0.001$ ) and participate in a sickness absence interview ( $p = 0.009$ ).

Table III presents the responders’ assessment of encounters. High support was most often reported from the healthcare system and the personal system with considerable variation within this group with the GP being reported as highly supportive by 66% compared to 83% for the psychologist. Encounters



Table III. Percentages and odds ratios of high support from RTW-stakeholders for women compared to men ( $N = 226$ ).

	Total <i>N</i> (%)	Women <i>N</i> (%)	Men <i>N</i> (%)	Crude OR (95 % CI)	Adjusted <sup>1</sup> OR (95 % CI)
<b>Health</b>					
<i>GP</i>	138 (65.7)	113 (66.5)	25 (62.5)	1.19 (0.58–2.43)	1.06 (0.47–2.35)
<i>Psychologist</i>	124 (82.7)	99 (82.5)	25 (83.3)	0.91 (0.32–2.75)	1.42 (0.44–4.60)
<i>Psychiatrist</i>	36 (59.0)	24 (54.5)	12 (70.6)	0.50 (0.15–1.66)	0.41 (0.11–1.60)
<b>Insurance</b>					
<i>Social insurance officers</i>	21 (16.2)	18 (17.0)	3 (12.5)	1.43 (0.39–5.32)	1.37 (0.33–5.69)
<b>Work</b>					
<i>Supervisor</i>	62 (30.4)	46 (27.7)	16 (42.1)	0.53 (0.25–1.09)	0.32 (0.13–0.81)
<i>Colleges</i>	100 (48.8)	81 (47.6)	19 (54.3)	0.77 (0.37–1.59)	0.71 (0.31–1.66)
<i>Union</i>	46 (33.3)	40 (34.8)	6 (26.1)	1.51 (0.55–4.14)	1.97 (0.63–6.18)
<b>Personal</b>					
<i>Partner</i>	115 (81.6)	86 (77.5)	29 (96.7)	0.12 (0.02–0.92)	0.15 (0.02–1.25)
<i>Family</i>	142 (66.7)	117 (68.0)	25 (61.0)	1.36 (0.67–2.75)	1.39 (0.63–3.04)
<i>Friends</i>	162 (77.9)	138 (82.6)	24 (58.5)	3.37 (1.61–7.06)	4.34 (1.90–9.89)

<sup>1</sup>Adjusted for age, education, employment and RTW status, size and type of workplace and depressive symptoms

GP = General Practitioner

Table IV. Percentages and odds ratios for positive encounters with supervisor and social insurance officers for women compared to men ( $N = 226$ ).

	Total <i>N</i> (%)	Women <i>N</i> (%)	Men <i>N</i> (%)	Crude OR (95 % CI)	Adjusted <sup>1</sup> OR (95 % CI)
<b>Supervisor</b>					
<i>Provided support for RTW</i>	77 (34.8)	57 (31.8)	20 (47.6)	0.51 (0.26–1.02)	0.38 (0.17–0.85)
<i>Listened to me</i>	87 (39.2)	62 (34.4)	25 (59.5)	0.36 (0.18–0.71)	0.19 (0.08–0.45)
<i>Showed sympathy for my situation</i>	92 (41.6)	69 (38.5)	23 (54.8)	0.52 (0.26–1.02)	0.31 (0.13–0.73)
<i>Feel I had to justify my absence</i>	72 (32.7)	60 (33.5)	12 (29.3)	1.22 (0.58–2.56)	1.32 (0.59–2.94)
<b>Social insurance officer</b>					
<i>Provided support for RTW</i>	6 (6.3)	5 (6.5)	1 (5.3)	1.25 (0.14–11.38)	0.60 (0.04–9.86)
<i>Showed sympathy for my situation</i>	58 (59.8)	45 (57.7)	13 (68.4)	0.63 (0.22–1.83)	0.50 (0.13–1.99)
<i>Took my condition seriously</i>	61 (62.2)	45 (57.0)	16 (84.2)	0.25 (0.07–0.92)	0.10 (0.02–0.64)

<sup>1</sup>Adjusted for age, education, employment and RTW status, size and type of workplace and depressive symptoms

GP = General Practitioner

with social insurance officers were least often reported to be highly supportive (16%). About one third assessed their supervisor as being highly supportive, whereas 49% assessed their colleagues as supportive. Compared to men, women assessed their supervisor as less supportive (OR = 0.32; CI: 0.13–0.81,  $p = 0.002$ ) but their friends as more supportive (OR = 4.34; CI: 1.90–9.89,  $p < 0.001$ ).

Table IV shows specific aspects of encounters with social insurance officers and supervisors. Almost 60% of the respondents assessed that the social insurance officers took their condition seriously and listened to them, but only 6% reported that they helped them RTW. Women were less likely to assess that the social insurance officers took their condition seriously (OR = 0.10; CI: 0.02–0.64,  $p = 0.01$ ).

About 40% reported that the supervisor listened and showed sympathy for their situation. One third

reported that their supervisor helped them RTW, but 33% felt they had to justify their absence. Women were less likely to feel that the supervisor helped them RTW (OR = 0.38; CI: 0.17–0.85,  $p = 0.02$ ), listened to them (OR = 0.19; CI: 0.08–0.45,  $p < 0.001$ ), or showed sympathy for their situation (OR = 0.31; CI: 0.13–0.73,  $p = 0.007$ ). When we repeated the analyses without adjustment for depressive symptoms, odds ratios remained virtually unchanged (data not shown).

## Discussion

In this article, we examined contact with and assessments of encounters with stakeholders from the health, insurance, work, and personal system among employees sick listed with CMD. We found, that besides stakeholders from the personal system,

healthcare professionals were most often assessed as highly supportive, especially the psychologist. The positive assessments might reflect that the psychologists, as opposed to the GP, do not function as a gate-keeper for sickness benefit. Earlier, Upmark [27] suggested that the imbalance between professionals and the patients may be widened when the professionals also have a gate-keeper function in relation to sickness benefits [27]. Considering that almost half of the respondents received psychological help during the last 3 months, the psychologist might be a key RTW-stakeholder for workers on sickness absence due to CMD, which potentially could have an important influence on the disabled workers decision to RTW.

Very few responders assessed their encounters with the social insurance officers as helpful for RTW and only 16% viewed the encounter as supportive. Findings from a study by Høgelund et al. showed that employees who participate in personal consultations with social insurance officers have a better chance to RTW than those who did not. However, this only applied to employees returning to their old workplace and not to employees returning to a new workplace [29].

Only 30% of participants reported high support from their supervisor. In Denmark, the employers pay for a relatively short period of sickness absence and it is easy to dismiss people on sickness absence. The employers' incentives for facilitating RTW must therefore be regarded as quite low in contrast to other countries, such as the Netherlands. In a Dutch study, Nieuwenhuijsen et al. [9] found that the quality of supervisory communication was related to the financial incentives for ensuring RTW [9]. Recently, the Danish policymakers have attempted to expand the role of the employer in the RTW-process. Payment of sickness benefit from the employer was increased from 2 weeks to 3 weeks, and all employers are now obliged to conduct sickness absence interviews with workers on sick leave [1]. These initiatives might strengthen the role of the employers and the supervisors in the RTW-process.

An important finding of our study is the identified gender differences. Women were less likely to participate in a sickness absence interview with their employer and less likely to assess the employer as supportive and respectful. Mandatory sickness absence interviews might decrease gender differences in the prevalence of these interviews among men and women, but are unlikely to change women's assessment. Therefore, it is important to improve supervisors' skills for communicating with sick listed employees. Regarding the encounters with the social insurance officers, women were less likely

than men to feel that the officers took their condition seriously.

Our results are in disagreement with findings from two Swedish studies. These studies found that women perceived their contact with healthcare and insurance officers as more supportive and positive than men [16,19]. However, a third Swedish study on negative encounters with healthcare professionals found that women agreed more strongly than men on statements such as 'Not believed what I said' and 'Did not listen' [27].

#### *Methodological considerations*

The strength of this study is that we included questions about assessment of encounters with stakeholders from all relevant systems, and we asked the respondents to assess each stakeholder individually. Prior studies have tended to collapse groups of stakeholders together [19,27]. It is also a strength of our study that the questions we used to assess encounters were based on previous research and theoretical considerations [16,19,26,27].

Although the response rate for the follow-up questionnaires was rather high, the low response rate for the baseline is a limitation of this study. The low response rate was expected, as earlier questionnaires studies in populations of sick listed employees have reported low response rates [16,27]. Moreover, our study population consisted of people suffering from CMD, which might further have contributed to the low response rate. We deliberately did not send out reminders to the baseline non-responders to avoid that they felt pressured to answer the questionnaire. Non-participation might have been due to severe illness, e.g. major depression. We found that employees sick-listed with self-reported stress-related conditions were more likely to respond to the follow-up questionnaire as opposed to employees sick-listed with self-reported depression. As severity of illness was related to assessment of encounters in an earlier study [16], we might have underestimated negative assessments. Also, almost 80% of the our responders were women, which partly reflects the high proportion of women among sickness benefit recipients with CMD, but also an underrepresentation of men. Thus the proportion of workers assessing high support from the supervisor might actually be lower, as women assessed the support lower than men. Moreover, it is possible that we did not find gender difference for other stakeholders because of lack of power as our sample only comprised 44 men. Finally, because there are great variations in the responsibilities and roles of stakeholders from country to country, results have to be understood in relation to the



specific Danish legislative and cultural context [2,3]. To our knowledge this is the first study conducted in Denmark on the topic.

## Conclusion

This study identified the psychologist as a key RTW-stakeholder who contributes positively to the RTW-experience. Whereas social insurance officers have been appointed a key role in the RTW-process in Denmark, few participants experiences these encounters as supportive or helpful for RTW. Gender differences in assessment of support were found mainly in relation to the supervisor and, to a lesser extent, the social insurance officers with women assessing these encounters as less supportive and less respectful than men.

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## Conflict of interest

None declared.

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